

907 KAR 1:055. Payments for primary care center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services.

RELATES TO: KRS 205.560, 216B.010, 216B.105, 216B.130, 216B.990, 42 C.F.R. 413, 438.60, 491, Subpart A, 440.130, 440.230, 447.3251, 45 C.F.R. 74.27, 48 C.F.R. Part 31, 42 U.S.C. 1396a, b, d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1), 216B.042, 42 U.S.C. 1396a

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Department for Medicaid Services' reimbursement policies for primary care center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services.

Section 1. Definitions. (1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).

(2) "Alternative payment methodology" or "APM" means a reimbursement that is an alternative to the standard reimbursement established in Section 3 of this administrative regulation in accordance with 42 U.S.C. 1396a(bb)(6).

(3) "Audit" means an examination that may be full or limited in scope of a federally-qualified health center's, federally-qualified health center look-alike's, rural health clinic's, or primary care center's:

(a) Financial transactions, accounts, and reports; and

(b) Compliance with applicable Medicare and Medicaid regulations, manual instructions, and directives.

(4) "Base year" means the first full fiscal year following the effective date of an FQHC's, FQHC look-alike's, or RHC's enrollment in the Medicaid program:

(a) In which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation as designated by the FQHC, FQHC look-alike, or RHC; and

(b) Not to exceed twenty-four (24) months past the effective date that the FQHC, FQHC look-alike, or RHC was enrolled with the department.

(5) "Certified psychologist with autonomous functioning" means an individual who is a certified psychologist with autonomous functioning pursuant to KRS 319.056.

(6) "Certified social worker" means an individual who meets the requirements established in KRS 335.080.

(7) "Change in scope of service" means a change in the type, intensity, duration, or amount of service.

(8) "Department" means the Department for Medicaid Services or its designated agent.

(9) "Enrollee" means a recipient who is enrolled with a managed care organization for the purpose of receiving Medicaid or KCHIP covered services.

(10) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(11) "Federally-qualified health center" or "FQHC" is defined in 42 C.F.R. 405.2401.

(12) "Federally-qualified health center look-alike" or "FQHC look-alike" means an entity that is currently approved by the United States Department of Health and Human Services, Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services to be a federally-qualified health center look-alike.

(13) "Final PPS rate" means an all-inclusive reimbursement amount per visit for an FQHC, FQHC look-alike, or RHC that:

- (a) Is unique to the FQHC, FQHC look-alike, or RHC;
- (b) Encompasses reimbursement for all services rendered during the visit;
- (c) Is based on:

1. Twelve (12) full months of Medicaid cost report data in which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation:

- a. Submitted to the department by the FQHC, FQHC look-alike, or RHC; and
- b. That has been reviewed and approved by the department; and

2. A paid claims listing corresponding to the twelve (12) full months of Medicaid cost report data in which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation; and

- (d) Is established by the department.

(14) "Health care provider" means, for:

- (a) A primary care center, an FQHC, an FQHC look-alike, or an RHC:

- 1. A licensed physician;
- 2. A licensed osteopathic physician;
- 3. A licensed podiatrist;
- 4. A licensed optometrist;
- 5. An advanced practice registered nurse;
- 6. A licensed dentist or oral surgeon;
- 7. A physician assistant;
- 8. A licensed clinical social worker;
- 9. A licensed psychologist;
- 10. A licensed marriage and family therapist;
- 11. A licensed professional clinical counselor;
- 12. A licensed psychological practitioner;
- 13. A certified psychologist with autonomous functioning; or
- 14. A practitioner who is:

a. Authorized pursuant to 907 KAR 1:054 to provide services in a PCC, an FQHC, an FQHC look-alike, or an RHC; and

- b. Not listed in subparagraphs 1 through 13 of this paragraph; or

(b) An FQHC or FQHC look-alike, in addition to the professionals established in paragraph (a) of this subsection:

- 1. A resident in the presence of a teaching physician; or
- 2. A resident without the presence of a teaching physician if:
 - a. The services are furnished in an FQHC or FQHC look-alike in which the time spent by the resident in performing patient care is included in determining any intermediary payment to a hospital in accordance with 42 C.F.R. 413.75 through 413.83;
 - b. The resident furnishing the service without the presence of a teaching physician has completed more than six (6) months of an approved residency program;
 - c. The teaching physician:
 - (i) Does not direct the care of more than four (4) residents at any given time; and
 - (ii) Directs care from a proximity that constitutes immediate availability; and
 - d. The teaching physician:
 - (i) Has no other responsibilities at the time;
 - (ii) Has management responsibility for any recipient seen by the resident;
 - (iii) Ensures that the services furnished are appropriate;

(iv) Reviews with the resident, during or immediately after each visit by a recipient, the recipient's medical history, physical examination, diagnosis, and record of tests or therapies; and

(v) Documents the extent of the teaching physician's participation in the review and direction of the services furnished to each recipient.

(15) "Interim PPS rate" means an all-inclusive per visit reimbursement amount established by the department to pay an FQHC, FQHC look-alike, or an RHC for covered services prior to the establishment of a final PPS rate.

(16) "Licensed clinical social worker" means an individual who is currently licensed in accordance with KRS 335.100.

(17) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(18) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(19) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(20) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(21) "Medical Group Management Association Medical Directorship and On-Call Compensation Survey" means a report developed and owned by the Medical Group Management Association that:

(a) Highlights the critical relationship between medical director compensation and time spent in the medical director function;

(b) Aligns medical director compensation with time spent as medical director; and

(c) Contains tables illustrating the relationship of medical director salary to time spent in the medical director function.

(22) "Medical Group Management Association Physician Compensation and Production Survey Report" means a report developed and owned by the Medical Group Management Association that:

(a) Highlights the critical relationship between physician salaries and productivity;

(b) Is used to align physician salaries and benefits with provider production; and

(c) Contains:

1. Performance ratios illustrating the relationship between compensation and production; and

2. Comprehensive and summary data tables that cover many specialties.

(23) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(24) "Medicare Economic Index" or "MEI" means the economic index referred to in 42 U.S.C. 1395u(b)(3)(L).

(25) "Paid claims listing" means a report of claims paid by the department for a given FQHC, FQHC look-alike, or RHC.

(26) "Parent facility" means a federally-qualified health center, federally-qualified health center look-alike, or primary care center that is:

(a) Licensed and operating with a unique Kentucky Medicaid program provider number;

(b) Operating under the same management as a satellite facility; and

(c) The original facility that existed prior to the existence of a satellite facility.

(27) "PCC" or "primary care center" means an entity that is currently licensed as a PCC in accordance with 902 KAR 20:058.

(28) "Percentage increase in the MEI" is defined in 42 U.S.C. 1395u(i)(3).

(29) "Physician assistant" is defined by KRS 311.840(3).

(30) "PPS" means prospective payment system.

(31) "Rate year" means, for the purposes of the MEI, the twelve (12) month period beginning July 1 of each year for which a rate is established for an FQHC, FQHC look-alike, or RHC under the prospective payment system.

(32) "Reasonable cost" means:

(a) A cost as determined by the:

1. Applicable Medicare cost reimbursement principles established in 42 C.F.R. Part 413, 45 C.F.R. 74.27, and 48 C.F.R. Part 31; and

2. Medical Group Management Association Physician Compensation and Production Survey Report for the applicable year and region; and

(b) Costs determined to be reasonable in accordance with a comprehensive desk review or audit.

(33) "Recipient" is defined by KRS 205.8451(9).

(34) "RHC" or "rural health clinic" is defined in 42 C.F.R. 405.2401(b).

(35) "Satellite facility" means a federally-qualified health center, federally-qualified health center look-alike, or primary care center that:

(a) Is at a different location than the parent facility; and

(b) Operates under the same management as the parent facility.

(36) "Telehealth" means two (2)-way, real time interactive communication between a patient and a physician or practitioner located at a distant site for the purpose of improving a patient's health through the use of interactive telecommunication equipment that includes, at a minimum, audio and video equipment.

(37) "Visit" means an encounter:

(a) Between a recipient or enrollee and a health care provider during which an FQHC, FQHC look-alike, or RHC service is delivered; and

(b) That occurs:

1. In person; or

2. Via telehealth if authorized by 907 KAR 3:170.

Section 2. Provider Participation Requirements. (1)(a) A participating FQHC, FQHC look-alike, RHC, or PCC shall be currently:

1. Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

2. Except as established in paragraph (c) of this subsection, participating in the Kentucky Medicaid program in accordance with 907 KAR 1:671.

(b) A satellite facility of an FQHC, an FQHC look-alike, or a PCC shall:

1. Be currently listed on the parent facility's license in accordance with 902 KAR 20:058;

2. Comply with the requirements regarding extensions established in 902 KAR 20:058; and

3. Comply with 907 KAR 1:671.

(c) In accordance with 907 KAR 17:015, Section 3(3), an FQHC, FQHC look-alike, RHC, or PCC that provides a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(2)(a) To be initially enrolled with the department, an:

1. FQHC or FQHC look-alike shall:

a. Enroll in accordance with 907 KAR 1:672; and

b. Submit to the department proof of its FQHC or FQHC look-alike designation issued by the Centers for Medicare and Medicaid Services; or

2. RHC shall:

a. Enroll in accordance with 907 KAR 1:672; and

b. Submit to the department proof of its RHC license issued by the Cabinet for Health and Family Services Office of Inspector General.

- (b) To remain enrolled and participating in the Kentucky Medicaid program, an:
1. FQHC or FQHC look-alike shall:
 - a. Comply with the enrollment requirements established in 907 KAR 1:672;
 - b. Comply with the participation requirements established in 907 KAR 1:671; and
 - c. Annually submit to the department proof of its FQHC or FQHC look-alike designation issued by the Centers for Medicare and Medicaid Services; or
 2. RHC shall:
 - a. Comply with the enrollment requirements established in 907 KAR 1:672;
 - b. Comply with the participation requirements established in 907 KAR 1:671; and
 - c. Annually submit to the department proof of its RHC license issued by the Cabinet for Health and Family Services Office of Inspector General.
- (c) The requirements established in paragraphs (a) and (b) of this subsection shall apply to a satellite facility of an FQHC or FQHC look-alike.
- (3)(a) An FQHC or FQHC look-alike that operates multiple satellite facilities shall:
1. List each satellite facility on the parent facility's license in accordance with 902 KAR 20:058; and
 2. Consolidate claims and cost report data of its satellite facilities with the parent facility.
- (b) A PCC that operates multiple satellite facilities shall list each satellite facility on the parent facility's license in accordance with 902 KAR 20:058.
- (4) An FQHC, FQHC look-alike, RHC, or PCC that has been terminated from federal participation shall be terminated from Kentucky Medicaid program participation.
- (5) A participating:
- (a) FQHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC;
 - (b) FQHC look-alike and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC look-alike;
 - (c) RHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an RHC; or
 - (d) PCC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of a PCC.
- (6) An FQHC, FQHC look-alike, RHC, or PCC performing laboratory services shall meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

Section 3. Standard Reimbursement for an FQHC, FQHC look-alike, or RHC for a Visit by a Recipient Who is not an Enrollee and that is Covered by the Department. (1) Except as established in Section 5 or Section 9 of this administrative regulation, for a visit by a recipient who is not an enrollee and that is covered by the department, the department shall reimburse:

- (a) An FQHC, FQHC look-alike, or RHC a final PPS rate as required by 42 U.S.C. 1396a(bb); or
 - (b) A satellite facility of an FQHC or FQHC look-alike a final PPS rate as required by 42 U.S.C. 1396a(bb).
- (2) Costs related to outpatient drugs or pharmacy services shall be excluded from the PPS rate referenced in subsection (1) of this section.
- (3) The department shall calculate a final PPS rate for a new FQHC, FQHC look-alike, or RHC in accordance with Section 4 of this administrative regulation.

- (4) The department shall adjust a final PPS rate:
 - (a) By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, or RHC services on July 1 of each year;
 - (b) In accordance with Section 10 of this administrative regulation:
 - 1. Upon request and documentation by an FQHC, FQHC look-alike, or RHC that there has been a change in scope of services; or
 - 2. Upon review and determination by the department that there has been a change in scope of services; and
 - (c) If necessary as a result of a desk review or audit.
- (5) A final PPS rate established in accordance with this administrative regulation shall not be subject to an end of the year cost settlement.

Section 4. Establishment of a Final PPS Rate for a New FQHC, FQHC look-alike, or RHC.

- (1)(a) The department shall establish a final PPS rate to reimburse a new FQHC, FQHC look-alike, or RHC 100 percent of its reasonable cost of providing Medicaid covered services utilizing information from the FQHC's, FQHC look-alike's, or RHC's base year upon completion of a comprehensive desk review or audit of an FQHC's, FQHC look-alike's, or RHC's Universal Cost Report.
- (b) Except for a time frame in which the department reimburses an FQHC, FQHC look-alike, or RHC an interim PPS rate, the final PPS rate established for an FQHC, FQHC look-alike, or RHC shall:
 - 1. Be prospective; and
 - 2. Not settled to cost.
- (2) The department shall determine the reasonable costs of an FQHC, FQHC look-alike, or RHC based on the:
 - (a) Universal Cost Report:
 - 1. Submitted by the FQHC, FQHC look-alike, or RHC to the department and prepared by the FQHC, FQHC look-alike, or RHC in accordance with the Universal Cost Report Instructions; and
 - 2. That contains twelve (12) full months of operating data for the designated base year;
 - (b) Department's review of the Universal Cost Report referenced in paragraph (a) of this subsection; and
 - (c) Costs and visits as adjusted by the department for full-time operation for a facility that is not in operation at least forty (40) hours per week.
- (3)(a) An FQHC, FQHC look-alike, or RHC shall submit a Universal Cost Report to the department by the end of the fifth month following the end of the FQHC's, FQHC look-alike's, or RHC's designated base year.
- (b) The department shall:
 - 1. Review the Universal Cost Report referenced in paragraph (a) of this subsection submitted by an FQHC, FQHC look-alike, or RHC within ninety (90) business days of receiving the Universal Cost Report; and
 - 2. Notify the FQHC, FQHC look-alike, or RHC of the necessity of the FQHC, FQHC look-alike, or RHC to submit additional documentation if necessary.
- (c)1. If additional documentation is necessary to establish a final PPS rate, the FQHC, FQHC look-alike, or RHC shall:
 - a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or
 - b. Request an extension beyond thirty (30) days to provide the additional documentation.
- 2. The department shall grant no more than one (1) extension.

3. An extension shall not exceed thirty (30) days.

(d)1. If the department requests additional documentation from an FQHC, FQHC look-alike, or RHC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, or RHC as it reimburses primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation until:

- a. The additional documentation has been received by the department; and
- b. The department has established a final PPS rate.

2. If an FQHC, FQHC look-alike, or RHC does not submit a Universal Cost Report to the department, the department shall reimburse the FQHC, FQHC look-alike, or RHC as it reimburses primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation until the FQHC, FQHC look-alike, or RHC submits a Universal Cost Report to the department.

(e) The department shall review an FQHC's, FQHC look-alike's, or RHC's paid claims listing for the period of time corresponding to the FQHC's, FQHC look-alike's, or RHC's cost report period of time referenced in paragraph (a) of this subsection.

(f)1. If an FQHC, FQHC look-alike, or RHC has submitted all necessary information to the department, within forty-five (45) days of reviewing the FQHC's, FQHC look-alike's, or RHC's paid claims listing, the department shall:

- a. Establish a final PPS rate for the FQHC, FQHC look-alike, or RHC; and
- b. Notify the FQHC, FQHC look-alike, or RHC in writing of the FQHC's, FQHC look-alike's, or RHC's:
 - (i) Final PPS rate; and
 - (ii) Appeal rights regarding the PPS final rate.

2. To allow adequate time for claim adjudication, a paid claims listing shall not be requested until at least fourteen (14) months after an FQHC's, FQHC look-alike's, or RHC's fiscal year end.

3. If an FQHC, FQHC look-alike, or RHC has not submitted all necessary information to the department to establish a final PPS rate, the department shall continue to pay the FQHC, FQHC look-alike, or RHC as it pays primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation.

(4) Along with a Universal Cost Report, an FQHC, FQHC look-alike, or RHC shall submit to the department a written statement of the FQHC's, FQHC look-alike's, or RHC's maximum hours per day, days per week, and weeks per year of operation.

Section 5. Interim Reimbursement for a New FQHC, FQHC Look-alike, or RHC. (1)(a) Until a final PPS rate is established for an FQHC, FQHC look-alike, or RHC, the department shall reimburse the FQHC, FQHC look-alike, or RHC an interim PPS rate based on the average final PPS rates of entities with similar caseloads.

(b) To identify an entity with a similar caseload, the department shall consider:

1. Entity type (FQHC, FQHC look-alike, or RHC);
2. Managed care organization region;
3. Operating hours per day, days per week, and weeks per year; and
4. Specialty services, obstetrical services, or hospital-based entities, if applicable.

(2) If no entity with a similar caseload exists, the department shall establish an interim PPS rate using cost reporting methods.

(3) After the department establishes a final PPS rate for an FQHC, FQHC look-alike, or RHC, the department shall retroactively adjust reimbursement to the FQHC, FQHC look-alike, or RHC that was made on an interim basis to comport with the final PPS rate.

(4) An FQHC, FQHC look-alike, or RHC, upon enrolling with the Medicaid Program, shall submit in writing to the department a statement stating the FQHC's, FQHC look-alike's, or RHC's maximum hours per day, days per week, and weeks per year of operation.

Section 6. Reimbursement for Services or Drugs Provided to an Enrollee by a PCC That is Not an FQHC, FQHC Look-Alike, or RHC and that are Covered by an MCO. (1) For a service or drug provided to an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC and that is covered by an MCO, the PCC's reimbursement shall be the reimbursement established pursuant to an agreement between the PCC and the managed care organization with whom the enrollee is enrolled.

(2) The department shall not supplement the reimbursement referenced in subsection (1) of this section.

Section 7. Reimbursement for Services or Drugs Provided to a Recipient by a PCC That is Not an FQHC, FQHC Look-Alike, or RHC and that are Covered by the Department. (1)(a) For a service or drug provided to a recipient that is not an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC, the department shall reimburse the rate or reimbursement established for the service or drug on the current Kentucky-specific Medicare Physician Fee Schedule.

(b)1. Except as provided in subparagraph 3. of this paragraph, if no rate or reimbursement exists on the Kentucky-specific Medicare Physician's Fee schedule for a service or drug referenced in paragraph (a) of this subsection, the department shall reimburse for the service or drug the same amount that the department reimburses for the service or drug pursuant to the applicable administrative regulation established in Title 907 KAR.

2. For example, if no reimbursement exists on the current Kentucky-specific Medicare Physician Fee Schedule for a:

a. Dental service, the department shall reimburse for the dental service pursuant to 907 KAR 1:626; or

b. Given physician's service, the department shall reimburse for the service pursuant to 907 KAR 3:010.

3. The department shall reimburse a rate equal to seventy-five (75) percent of the rate it pays a physician pursuant to 907 KAR 3:010 for a physician's service that:

a. Does not exist on the current Kentucky-specific Medicare Physician Fee Schedule; and

b. Is provided by an APRN or physician assistant.

(2) The reimbursement referenced in subsection (1) of this section shall not exceed the federal upper payment limit determined in accordance with 42 C.F.R. 447.321.

(3)(a) The coverage provisions and requirements established in 907 KAR 3:005 shall apply to a service or drug provided by a PCC.

(b) If a Medicare coverage provision or requirement exists regarding a given service or drug that contradicts a provision or requirement established in 907 KAR 3:005, the provision or requirement established in 907 KAR 3:005 shall supersede the Medicare provision or requirement.

Section 8. Supplemental Reimbursement for FQHC Visits, FQHC Look-Alike Visits, and RHC Visits. If a managed care organization's reimbursement to an FQHC, FQHC look-alike, or RHC for a visit by an enrollee to the FQHC, FQHC look-alike, or RHC is less than what the FQHC, FQHC look-alike, or RHC would receive pursuant to Sections 3, 4, 5, or 9 of this administrative regulation, the department shall supplement the reimbursement made by the managed care organization in a manner that:

- (1) Equals the difference between what the managed care organization reimbursed and what the reimbursement would have been if it had been made in accordance with Sections 3, 4, 5, or 9 of this administrative regulation;
- (2) Is in accordance with 42 U.S.C. 1396a(bb)(5)(A); and
- (3) Ensures that total reimbursement does not exceed the federal upper payment limit in accordance with 42 C.F.R. 447.304.

Section 9. Alternative Payment Methodology for an FQHC, FQHC Look-alike, or RHC.

(1)(a) The department shall pay to an FQHC, FQHC look-alike, or RHC, for which a final PPS rate exists, an alternative payment methodology if the FQHC, FQHC look-alike, or RHC notifies the department in writing that it requests to receive the alternate reimbursement.

(b)1. The APM shall equal 125 percent of the Medicare upper payment limit for rural health clinics in effect on September 30, 2014.

2. The APM referenced in subparagraph 1 of this paragraph shall not be adjusted for inflation.

(c) An FQHC, FQHC look-alike, or RHC that had an interim PPS rate prior to November 1, 2015 may request the APM as an interim PPS rate until the FQHC's, FQHC look-alike's, or RHC's final PPS rate is established.

(2)(a) An APM established in this section shall be effective for dates of service beginning with the date requested in writing by an FQHC, FQHC look-alike, or RHC except as established in paragraph (b) of this subsection.

(b) An APM effective date shall not precede the date in which the department received the written request for the APM.

Section 10. Change in Scope and Final PPS Rate Adjustment. (1)(a) If an FQHC, FQHC look-alike, or RHC changes its scope of services after the base year, the department shall adjust the FQHC's, FQHC look-alike's, or RHC's final PPS rate if the change in scope qualifies for an adjustment in accordance with this section upon departmental review and approval of the change in scope.

(b) An adjustment to a final PPS rate resulting from a change in scope that occurred after an FQHC's, FQHC look-alike's, or RHC's base year shall be effective to the date that the change in scope occurred.

(c)1. A revised PPS rate shall be calculated in accordance with the MAP 100501.

2. A revised PPS rate shall not be rebased.

(2) A change in scope of service shall be restricted to:

(a) Adding or deleting a covered service;

(b) Increasing or decreasing the intensity of a covered service pursuant to subsection (5) of this section; or

(c) A statutory or regulatory change that materially impacts the costs or visits of an FQHC, FQHC look-alike, or RHC.

(3) The following items individually shall not constitute a change in scope:

(a) A general increase or decrease in the costs of existing services;

(b) A reduction or an expansion of hours per day, days per week, or weeks per year;

(c) An addition of a new site that provides the same Medicaid covered services;

(d) A wage increase;

(e) A renovation or other capital expenditure;

(f) A change in ownership; or

(g) An addition or deletion of a service provided by a non-licensed professional or specialist.

(4)(a) An addition of a covered service shall be restricted to the addition of a licensed pro-

fessional staff member who can perform a Medicaid covered service that is not currently being performed within the FQHC, FQHC look-alike, or RHC by a licensed professional employed or contracted by the facility.

(b) The deletion of a covered service shall be restricted to the deletion of a licensed professional staff member who can perform a Medicaid covered service that was being performed within the FQHC, FQHC look-alike, or RHC by the licensed professional staff member.

(5) A change in intensity shall:

(a) Include a material change;

(b) Increase or decrease the existing final PPS rate by at least five (5) percent; and

(c) Last at least twelve (12) months.

(6) The department shall consider a change in scope request due to a statutory or regulatory change that materially impacts the costs of visits at an FQHC, FQHC look-alike, or RHC if:

(a) A government entity imposes a mandatory minimum wage increase and the increase was:

1. Not included in the calculation of the final PPS rate; or

2. Subsequently included in the MEI applied yearly; or

(b)1. A new licensure requirement or modification of an existing requirement by the state results in a change that affects all facilities within the class.

2. A provider shall document that an increase or decrease in the cost of a visit occurred as a result of a licensure requirement or policy modification.

(7) A requested change in scope shall:

(a) Increase or decrease the existing final PPS rate by at least five (5) percent;

(b) Last at least twelve (12) months; and

(c) Be submitted to the department in writing.

(8)(a) An FQHC, FQHC look-alike, or RHC that requests a change in scope shall submit the following documents to the department within six (6) months of the requested effective date of a change in scope:

1. A narrative describing the change in scope;

2. A completed MAP 100501, Prospective Payment System Rate Adjustment, completed according to the Instructions for Completing the MAP 100501 Form; and

3. A signed letter requesting the change in scope.

(b) If the department does not receive the documentation required regarding a change in scope within six (6) months after the requested effective date of a change in scope, the change in scope shall be denied.

(c)1. The department shall:

a. Review the documentation listed in this subsection; and

b. Notify the FQHC, FQHC look-alike, or RHC in writing of the:

(i) Approval or denial of the request for change in scope within ninety (90) business days from the date the department received the request; or

(ii) Need for additional documentation from the FQHC, FQHC look-alike, or RHC to establish an interim PPS rate associated with the change in scope.

2. If the department requests additional documentation to calculate the interim PPS rate for a change in scope, the FQHC, FQHC look-alike, or RHC shall:

a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or

b. Request an extension beyond thirty (30) days to provide the additional documentation.

3.a. The department shall grant no more than one (1) extension.

b. An extension shall not exceed thirty (30) days.

4. If the department approves the request for a change in scope and receives all of the nec-

essary documentation from an FQHC, FQHC look-alike, or RHC within the timelines established in this section, the department shall establish an interim PPS rate for the FQHC, FQHC look-alike, or RHC based on the projected costs contained in the completed MAP 100501, Prospective Payment System Rate Adjustment referenced in paragraph (a)2 of this subsection.

(9)(a) To establish a PPS final rate resulting from a change in scope, the department shall use a completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report submitted by the FQHC, FQHC look-alike, or RHC to the department that contains twelve (12) months of cost data for the first full fiscal year end after the effective date of the change in scope.

(b) Within six (6) months of the end of the twelve (12) month cost data period referenced in paragraph (a) of this subsection, the FQHC, FQHC look-alike, or RHC shall submit to the department the completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report containing cost data corresponding to the twelve (12) month cost data for the first full fiscal year end after the effective date of the change in scope.

(c) The department shall:

1. Review the completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report referenced in paragraph (a) of this subsection submitted by an FQHC, FQHC look-alike, or RHC within ninety (90) business days of receiving the completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report; and

2. Notify the FQHC, FQHC look-alike, or RHC of the necessity of the FQHC, FQHC look-alike, or RHC to submit additional documentation if necessary.

(d)1. If additional documentation is necessary to establish a PPS final rate, the FQHC, FQHC look-alike, or RHC shall:

- a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or

- b. Request an extension beyond thirty (30) days to provide the additional documentation.

2. The department shall grant no more than one (1) extension.

3. An extension shall not exceed thirty (30) days.

(e)1. If the department requests additional documentation from an FQHC, FQHC look-alike, or RHC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, or RHC the FQHC's, FQHC look-alike's, or RHC's PPS final rate that was in effect prior to the FQHC's, FQHC look-alike's, or RHC's request for a change in scope until:

- a. The additional documentation has been received by the department; and

- b. The department establishes a new final PPS rate associated with the change in scope.

2. If an FQHC, FQHC look-alike, or RHC does not submit a completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report to the department in accordance with paragraph (b) of this subsection, the department shall:

- a. Not issue a new PPS final rate associated with the change in scope; and

- b. Revert to paying the FQHC, FQHC look-alike, or RHC the FQHC's, FQHC look-alike's, or RHC's PPS final rate that was in effect prior to the FQHC, FQHC look-alike, or RHC requesting a change in scope.

(f)1. If any service included in a change in scope is a service that can be identified on a paid claims listing, the department shall review the FQHC's, FQHC look-alike's, or RHC's paid claims listing for the period of time corresponding to the FQHC's, FQHC look-alike's, or RHC's cost report period of time referenced in paragraphs (a) and (b) of this subsection.

2. If an FQHC, FQHC look-alike, or RHC has submitted all necessary information to the department, within forty-five (45) days of reviewing the FQHC's, FQHC look-alike's, or RHC's

paid claims listing, the department shall:

a. Establish a final PPS rate, resulting from the change in scope, for the FQHC, FQHC look-alike, or RHC; and

b. Notify the FQHC, FQHC look-alike, or RHC in writing of the FQHC's, FQHC look-alike's, or RHC's:

(i) Final PPS rate; and

(ii) Appeal rights regarding the PPS final rate.

3. To allow adequate time for claim adjudication, a paid claims listing shall not be requested until at least fourteen (14) months after the end of the FQHC's, FQHC look-alike's, or RHC's cost report period associated with the change in scope.

(g)1. If no service included in a change in scope can be identified on a paid claims listing, and the department has received a completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report referenced in paragraphs (a) and (b) of this subsection, and no additional documentation is needed from the FQHC, FQHC look-alike, or RHC, the department shall:

a. Not review a paid claims listing in establishing a new PPS final rate for an FQHC, FQHC look-alike, or RHC resulting from the change in scope; and

b. Establish a new PPS final rate for an FQHC, FQHC look-alike, or RHC resulting from the change in scope within ninety (90) days of receiving the completed MAP 100501, Prospective Payment System Rate Adjustment and Universal Cost Report.

Section 11. Limitations and Exclusions. (1)(a) Except for a case in which a recipient or enrollee, subsequent to the first encounter at an FQHC, FQHC look-alike, or RHC, suffers an illness or injury requiring additional diagnosis or treatment, an encounter with more than one (1) health care provider or multiple encounters with the same health care provider which take place on the same day and at a single location shall constitute a single visit.

(b) The limit established in paragraph (a) of this subsection shall:

1. Apply to an FQHC, FQHC look-alike, or RHC; and

2. Not apply to a PCC that is not an FQHC, FQHC look-alike, or RHC.

(2)(a) Except as established in paragraph (b) of this subsection, a vaccine available without charge to an FQHC, FQHC look-alike, RHC, or PCC through the department's Vaccines for Children Program and the administration of the vaccine shall not be reported as a cost to the Medicaid Program.

(b) Adult flu vaccine costs shall be allowed as Medicaid costs reported on a Universal Cost Report.

(3) The department shall not reimburse for services provided by an FQHC, FQHC look-alike, PCC, or RHC to a recipient in a hospital unless the FQHC, FQHC look-alike, PCC, or RHC has previously, any time prior to the hospital admission, provided a service to the recipient at the FQHC's, FQHC look-alike's, PCC's, or RHC's location.

Section 12. Out-of-State Providers. (1) Except as established in subsection (2) of this section, reimbursement to an out-of-state FQHC, FQHC look-alike, or RHC shall be based on the rate on file with the FQHC's, FQHC look-alike's, or RHC's state Medicaid agency.

(2) If an out-of-state FQHC's, FQHC look-alike's, or RHC's reimbursement is an APM, the department's reimbursement to the out-of-state FQHC, FQHC look-alike, or RHC shall:

(a) Not be the APM the FQHC, FQHC look-alike, or RHC receives in its state; and

(b) Be the final PPS rate that the FQHC, FQHC look-alike, or RHC would receive in its state if it were not receiving an APM.

Section 13. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the reimbursement; and
- (2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 14. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

- (1)(a) 907 KAR 1:054; or
- (b) 907 KAR 1:082; and
- (2) This administrative regulation.

Section 15. Appeal Rights. An FQHC, FQHC look-alike, PCC, or RHC may appeal a department decision as to the application of this administrative regulation as it impacts the facility's reimbursement rate in accordance with 907 KAR 1:671.

Section 16. Incorporation by Reference. (1) The following material is incorporated by reference:

- (a) "MAP 100501, Prospective Payment System Rate Adjustment", February 2013 edition;
- (b) "Instructions for Completing the MAP 100501 Form", February 2013 edition;
- (c) "Universal Cost Report", May 2015; and
- (d) "Universal Cost Report Instructions", May 2015.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (2 Ky.R. 492; eff. 4-14-1976; 5 Ky.R. 67; eff. 9-6-1978; 10 Ky.R. 323; eff. 9-7-1983; 11 Ky.R. 291; eff. 9-11-1984; 1094; eff. 2-12-1985; 12 Ky.R. 282; eff. 9-10-1985; Recodified from 904 KAR 1:055, 5-2-1986; 13 Ky.R. 389; eff. 9-4-1986; 15 Ky.R. 1326; eff. 12-13-1988; 1981; eff. 3-15-1989; 16 Ky.R. 281; eff. 9-20-1989; 2601; eff. 6-27-1990; 18 Ky.R. 543; eff. 10-6-1991; 29 Ky.R. 824; 1279; eff. 10-16-2002; 40 Ky.R. 49; 299; eff. 9-6-2013; 41 Ky.R. 2674; 42 Ky.R. 782; 1208; eff. 11-6-2015.)